Intensive Care Coordination (ICC)
Frequently Asked Questions

- ***Question: Our locality already has Utilization Management (UM) staff, so do I have to terminate this staff person and have the Intensive Care Coordinator perform the utilization management duties?***

  Answer: No, as long as the UM function is completed in some way for these cases, it does not matter who performs it. The position description provided with the Intensive Care Coordination Guidelines is one example that localities may use.

- ***Question: Our locality has someone that works out of our CSA office that performs the duties described in the Intensive Care Coordination Guidelines. Can she continue as the Intensive Care Coordinator or will this person need to work at the CSB? We still plan to provide supervision for the ICC at the CSB.***

  Answer: Yes, the person at the CSA office can still provide the service but a contract will have to be worked out with the CSB as they will be responsible for oversight of the position. In order for the service to be considered ICC, the caseload must not exceed 12 at any time.

- ***Question: Does the CSB have the power to make the final determination regarding placement and treatment for the ICC cases?***

  Answer: No, the Intensive Care Coordinator makes recommendations to the FAPT, and then the FAPT decides as a team regarding the services to put in place.

- **Question: Do the services recommended by the Intensive Care Coordinator have to be provided by the CSB?**

  Answer: No, these services can be provided by any provider the FAPT feels is qualified to perform the services which could be the CSB but could be any other private or public provider. In fact, it is not the intent that the Intensive Care Coordinator provide the services, rather they would assess service needs and locate and arrange for all of the services necessary to assure community tenure for the child.

- ***Question: Is there a deadline for implementation of Intensive Care Coordination?***

  Answer: The Guidelines became effective July 1, 2008 so it is expected that communities begin the implementation process now if they have not done so already. Many communities already provide Intensive Care Coordination. There is no established deadline for completion, as we realize this will be an evolving process, requiring more time in some communities than others.

- ***Question: Is ICC mandated and required to be provided in each community, or is it an option based on local factors?***

  Answer: The guidelines are flexible to allow for the diversity in localities. Due to resource allocation or other considerations, it is not mandated that every local government have their own ICC. However, it is expected that the service will be offered. This could mean that some localities could work together to offer the service. It is expected that every CSB will either provide intensive care coordination or contract with another entity to provide it.

- ***Question: Is there a statewide rate for billing Intensive Care Coordination to CSA?***

  Answer: No. The state does not plan to set one rate for Intensive Care Coordination services. Some communities have already established a rate that works for them. Currently, the Intensive Care Coordination Implementation Workgroup is looking at coming up with some examples of rate methodologies that could be used, or are currently being used. The work of this group is scheduled to be completed December 1, 2008 and information developed by the workgroup, such as examples of rates, will be made available to all communities.

- ***Question: Is Intensive Care Coordination the same as Targeted Case Management that is provided by CSBs and is reimbursable to the CSB by Medicaid?***

- **Answer:** No, although there may be some overlapping duties. Some major differences between the two roles are that the ICC caseload is small (no more than 12 cases) which allows for a more intensive, thorough, and holistic clinical assessment. Also, the ICC role is time-limited and is for the purpose of transitioning a youth from residential care or preventing a youth from going in to care. The ICC will be involved with ensuring that

the family's needs are being considered in the development of services and will include the creation of services through informal or natural supports. The ICC is also responsible for the development of a 24 hour crisis plan, brokering of services with providers, and may be involved with the CPMT in identifying and forming needed services within the community. The agency case manager whom is responsible for targeted case management duties may remain involved in the case but to a lesser degree while ICC is being implemented. Once the ICC completes their time-limited service, the targeted case management provider may resume billing Medicaid for targeted case management services.

Questions that come up frequently will continue to be posted to this site. We have been answering individual questions on a regular basis since July 1 and will continue to do so. If you have a question, or just need assistance in getting started with ICC, please contact Pam Fisher, DMHMRSAS, by phone at 804-786-0158 or by e-mail at pamela.fisher@co.dmhmrsas.virginia.gov.